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THE MEDICAL-SOCIAL ASPECTS OF CARE GIVEN TO ALL NEW PATIENTS SEEN IN THE ADULT CARDIAC CLINIC OF THE MASSACHUSETTS MEMORIAL HOSPITALS JANUARY, FEBRUARY AND MARCH, 1947

A Thesis

Submitted by

Charlotte Chaletzky

(A. B., University of Massachusetts, 1946)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1948

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CHAPTER I

INTRODUCTION

The function of the heart as the core of the individual's life and strength is of tremendous significance to each human being. Damage to this organ constitutes a threat which varies not only with the degree of severity of the disease, but with the individual emotional make-up. Potential sources of social differences exist in the very nature of heart disease itself; in the sudden danger of its acute phases, in the possibility of recurrence and progression, and in its chronicity. The incidence of heart disease in all age groups -- in children, young adults, middle aged and elderly persons -- implies unfavorable influences in varying degrees upon the activities of life.[1]

Purpose and Limitations of Study

The original purpose of the study was twofold, namely, to learn how many patients with cardiac conditions are receiving assistance from the Department of Public Welfare, and to learn if the patients seen in the Cardiac Clinic have adequate facilities to carry out the physician's recommendation such as opportunity for rest, proper diet, medication

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[1] Ethel Cohen, "The Social Component in Heart Disease," The American Heart Journal, 16:422, October, 1938.

and transportation to clinic.

The writer originally set herself these two purposes and planned to study the problem in the manner outlined below. After studying the case records of the hospital, it became evident that the second objective could not be achieved. Therefore, it was necessary to modify the purpose, and the study now presented purports to show certain medical-social aspects of the patients.

In making this study, the writer discovered that medical recommendations and treatment as stated in the medical records were too vague to classify. The degree of severity of the illness itself or the limitations imposed were not clearly enumerated. Patients were not classified in accordance with the criteria set up by the American Heart Association. Consequently, the writer was unable to determine in detail whether or not patients actually were following exactly the medical recommendations which the physicians had intended.

This study does not include enough cases for final conclusions to be drawn. However, it is hoped that some general characteristics evidenced by the patients studied may be considered a sample of the total case load.

Scope of Study

The study comprises the forty-five patients, ranging in age from five months to seventy-six years, who were seen for the first time in the Cardiac Clinic of the Massachusetts

Memorial Hospitals over a period of three months -- January, February and March, 1947.

Method of Procedure

Schedules,[2] each listing items considered to be relevant to this study, were filled out for each patient and the data were classified and evaluated.

All forty-five medical records were read. Identifying data and medical aspects, including diagnosis and treatment were recorded. It was discovered, after reading the records, that only twenty-nine of the original forty-five patients were suffering with heart disease. Sixteen patients were diagnosed as not having any type of cardiac disorder.

Since many of the twenty-nine cardiac patients lived in outlying districts of Boston, it would have been impossible for the writer to have visited each one. As a result, the cooperation of the Visiting Nurse Association in these communities was requested. Questionnaires[3] for twelve patients residing outside of Boston were sent to the offices of the Visiting Nurse Association in those particular communities together with a letter[4] explaining the purpose of the study. Reports were received from the Association on these twelve individuals. However, only five patients were contacted. Of the seven remaining, two patients had died, one was in a

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[2] For copy of schedule see pp. 64, 65.
[3] For copy of questionnaire see pp. 66, 67.
[4] For copy of letter see p. 68.

hospital, and four could not be located.

The writer visited seventeen patients. Thirteen interviews were successfully completed. Of the four remaining, one patient had died, and three could not be located. Consequently, most of the conclusions will be based on the facts gleaned from the eighteen interviews.

The questionnaires to the Visiting Nurse Associations were sent in December, 1947. Replies were requested by the end of January, 1948. However, several of the Associations informed the writer that the replies would be delayed because of the shortages in their personnel. The last questionnaire was not received until May, 1948. The writer completed her interviews in June, 1948. Therefore, the time lapse between the patient's initial visit to the clinic and the date of his interview varied between one year to one year and five months.

The writer read the medical records during the months of October, November and December, 1947. At that time, twelve of the eighteen cardiac patients who were interviewed were regularly attending the clinic, four had been discharged, six were told to return if necessary, and seven patients did not keep their appointments to return to the clinic. In respect to plans made for discharged patients, one was hospitalized for observation, and the remaining three patients were discharged to their homes.

After consulting the social service notes that are recorded in the Cardiac Clinic records, the writer discovered that only eight of the twenty-nine cardiac patients were seen by a social worker. All eight interviews were routine social reviews.[5] Two of these patients evidenced social problems. One was referred to the Psychiatric Clinic of the Massachusetts General Hospital and the other was referred to a Family Society for case work service.

All patients who were interviewed were most cooperative in supplying the information which was requested from them.

Value of the Study

The physician in charge of the Cardiac Clinic requested that a study be made to determine the answers to the questions enumerated in the purpose of the study. He believes that the clinic is serving a large number of patients who are receiving aid from the Department of Public Welfare, and that they do not have sufficient funds to adequately carry out medical recommendations. This study may also point out that with more intensive case work and social reviews, constructive help could be given by the social service department to those patients who are willing to carry out the medical recommendations given by the physician in the Cardiac Clinic.

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[5] Infra, p. 50.

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[5] Infra, p. 50.

CHAPTER II

BACKGROUND OF STUDY

History of the Hospital[1]

The Massachusetts Memorial Hospitals are considered to be one of the largest and most thoroughly equipped medical centers in New England. Six memorial units form the constituents of the hospital: for research, the Evans Memorial; for out-patient care, the Talbot Memorial; for ward and private patients, the Robinson and Collamore Memorials; for private bed care, the Private Pavillion; and for contagious diseases, the Haynes Memorial. Practically every phase of medical need is covered by these six units. In addition to care given in the hospital, district physicians visit the sick in their homes and a well-organized obstetrical staff provides home confinement care for mothers who do not require the service of the city's crowded maternity wards.

In the early 1800's, a group of Boston doctors, concerned with the problem of more adequate medical care, became interested in the homeopathic principle of treatment.

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[1] Massachusetts Memorial Hospitals.
A Guide for Volunteers, Boston Council of Social Agencies, 1940.
Let's Glance Through the Massachusetts Memorial Hospitals. An annonymous publication found at the Massachusetts Memorial Hospitals.

Although this new principle was arousing world-wide interest, its practice was not condoned by the orthodox medical society. Eventually, the Homeopathic practitioners were expelled from the Boston Medical Society. In 1841, they organized their own society, the Massachusetts Homeopathic Fraternity, which afterwards became the Homeopathic Fraternity and was the foundation of the present Massachusetts Memorial Hospitals.

The need of a dispensary and hospital to carry out the special treatment was soon felt and a charter was granted as far back as 1855. Around 1871, the Boston University School of Medicine was opened under the auspices of Homeopathic physicians and fell heir to the buildings and land of the New England Female Medical College. The hospital still maintains its close association with this medical school by serving as a teaching hospital.

From the City of Boston, a lot of land adjoining the Boston University Medical School was purchased, and a forty-bed hospital, the present Talbot Memorial or Out-Patient Department, was opened in the spring of 1876. A state grant of $120,000 made it possible for surgical and medical wings to be added in 1884 and 1891.

In 1885, a Nurses Training School was established in connection with the hospital. The hospital's affiliation with the Boston University Medical School makes it possible

to provide excellent instruction and the hospital itself offers an opportunity to obtain experience in practically every branch of nursing.

The second of the memorial units, the Haynes Memorial, was built in Brighton, Massachusetts in 1908 for the treatment of contagious diseases. It receives patients from more than seventy-five muncipalities whose boards of health look to this department for the reception and treatment of their citizens ill with communicable diseases and requiring hospitalization. Students of Boston University and Harvard Medical Schools and the Harvard School of Public Health receive instruction in the care and treatment of contagious diseases.

A vitally important work of the hospital is being carried on at the Robert Dawson Evans Department of Clinical Research and Preventive Medicine which was opened in 1912. Its purpose was a threefold one: first, to investigate causes of disease; second, to discover new treatment methods; and third, to prevent disease through education. The influence of this department is much further extended through cooperation with other institutions and agencies. Illustrative of this service, important contributions have been made to the study of heart diseases at Evans by the use of X-ray. Here also has been developed the ingenious mechanical heart which simulates diseases of the heart for demonstration and research work.

In 1916, the Robinson Memorial building was erected and in 1935, the Collamore Memorial, which provides the latest in modern equipment and comfort for the care of the sick, was added. These two units today form the main hospital.

The latest addition to the Massachusetts Memorial Hospitals was the Private Pavilion which was opened in 1947.

By the end of the century, homeopathy began to decline, and the name of the hospital was officially changed. The memorial unity, each bearing the name of a benefactor who had been influential in the development of the institution, were incorporated under a new title, The Massachusetts Memorial Hospitals.

In 1920, a Social Service Department with one worker was established. Gradually the department increased to meet more adequately the medical social needs of the patients. Today, the Social Service staff is composed of five workers and the chief of the department. Varying numbers of students from Boston schools of social work complete their requirements for medical social work field placements under very competent supervision in this department.

A Volunteer Service was organized in 1937. The number of volunteers vary from month to month. There have been as many as one hundred and sixty-five individuals who have

volunteered their services during one month in 1948. Volunteers serve as clinic secretaries, typists, messengers, ward helpers, blood bank receptionists, and in folding gauze and making dressings.

Briefly, the purposes of a modern hospital are: first, to give care to the sick; second, to add to the body of scientific knowledge of health and disease through research; and third, to provide opportunity for teaching. The Massachusetts Memorial Hospitals, a Grade A hospital, approved by the American College of Surgeons, and the American Medical Association, is fulfilling all these purposes.

Procedures in the Cardiac Clinic[2]

On May 27, 1925, a Cardiac Clinic was established in the Out-Patient Department of the Massachusetts Memorial Hospitals. The clinic, however, was very poorly organized. No records were kept and there is no data available concerning its function.

The clinic was reorganized in 1940 and was certified by the American Heart Association. It originated primarily as a consultation clinic but has gradually expanded its facilities to extend over routine care for patients. Theoretically, every patient should be referred from the general medical clinic, since the Cardiac Clinic operates as a

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[2] Information about the Cardiac Clinic was obtained through discussion with Dr. Norman Boyer, Chief of Clinic.

special section of this division. However, some exceptions are made in the cases of referrals from physicians, other clinics, and patients who are attending the hospital clinic for the first time.

The hospital and clinic staff constitute one organization. There is a ward service in connection with the Cardiac Clinic which is available for hospitalization when recommended either for study of clinic cases or for treatment of patients unable to obtain the proper care in their homes. The clinic also serves as a return clinic for patients discharged from the wards.

The clinic meets one afternoon a week. There are eight physicians in attendance who see between twenty-five and forty patients during each clinic session. Staff conferences are held about once a month for the discussion of cases and clinic problems. There are facilities for consultation in all required specialties. Adequate nursing service is provided in the clinic.

Patients are limited to such numbers as can receive adequate care, for it is realized that an unduly large attendance will necessitate hasty examinations and curtail the service which would be rendered each patient and result in the ineffectual care of many.

There is a clinic fee of one dollar. However, no

patient is turned away from the clinic because of lack of funds. If a patient can not afford the clinic fee, he is referred to the registrar of the Out-Patient Department who makes the necessary arrangements so that the patient may be treated without charge. Laboratory costs include three dollars each for an electrocardiogram and fluroscopy. This low charge was made possible by the donation of these machines by a publicly spirited individual. Here again, if the patient can not afford laboratory costs, he can obtain them free.

The clinic does not wish, however, to serve the "indigent" of Boston, for these people can turn to the Boston City Hospital for treatment. Instead, the clinic would prefer to extend its facilities to individuals living in outlying districts who have no claim on the services rendered by the Boston City Hospital. However, there is no policy to exclude treatment given to publicly aided patients.

The Chief of Clinic, or a physician designated by him, decides as the eligibility of the patient for admission to the clinic for a medical decision.

Only patients having organic heart disease, possible heart disease, or potential heart disease are enrolled in the clinic. The active case load is composed of patients on whom the etiological diagnosis and functional classification

have been recorded. Patients referred "for opinion only" are not included in the case load. These patients are referred to the Cardiac Clinic because the person who made the referral is not certain whether or not the patient actually has a heart condition. Many symptoms of heart disease may be produced by worry, and occasionally with anxiety neurosis there are heart symptoms such as headache, palpitation, and shortness of breath, but heart disease does not arise therefrom. For that reason, it is necessary to perform a reasonably complete physical examination and to carry out the laboratory tests in common use to determine if the suspected heart disease is a reality.

When a patient is enrolled in more than one clinic, such as cardiac and pre-natal, the responsibility for her medical care is shared jointly by these clinics.

On admission to the clinic, the medical history is obtained and a physical examination is made. Arrangements are made for the necessary laboratory examinations.

Clinic visits are made by prearranged appointments to prevent overcrowding of a clinic session. The patient is instructed to visit the clinic before the time of his appointment if he thinks it is necessary.

There are separate rooms for the examination of male and female patients, and a waiting room adjacent to the Cardiac Clinic. Suitable office space is provided for the

privacy of social workers' interviews with patients and their families.

Medical equipment includes:

1. scales and measuring rod
2. examining table and desk in each room
3. wooden tongue depressors
4. thermometers
5. sphygmomanometer in each examining room
6. spirometer
7. fluroscopic unit available

Facilities available are:

1. an electrocardiograph
2. an X-ray plant
3. a clinical laboratory
4. a pharmacy

CHAPTER III

SOME ASPECTS AND TREATMENT OF HEART DISEASE

Problem Created

Heart disease in the United States is much more common than either cancer or tuberculosis. The mortality from diseases of the heart and blood vessels is over three times as high as that from cancer and more than ten times as high as that from tuberculosis; in fact, heart disease shows a considerable greater toll than the sum of the following five leading causes of death: cancer, accidents, nephritis, pneumonia and tuberculosis, in that order.[1]

Heart disease is no respecter of age or persons. It is the leading fatal disease among children between the ages of ten and fifteen.[2]

> There are 35,000,000 people in the United States over the age of forty-five. One out of five has some form of heart disease. The total number of deaths in this group averages 1,000,000 a year. At least 450,000 deaths are due to diseases of the heart and blood vessels. Thus nearly one of every two deaths after the age of forty-five is caused by heart disease. One out of every three deaths in the United States is due to diseases of the heart and blood vessels.[3]

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[1] Paul D. White, "Heart Disease: Twenty-Seven Questions Answered." A reprint from Vogue, May, 1947. The Nast Publications, Inc.

[2] American Heart Association, Inc., One Out of Three.

[3] Ibid.

Just as with cancer and many other expert killers, the earlier phases of coronary disease usually give no warning signal. Few of the doomed men and women are aware of danger before the first actual attack which for some of them is also the last. Fortunately, "the death rate from the initial stab is less than five per cent among men who are not handicapped by high blood pressure or diabetes."[4]

Men are more prone than women to heart disease on the whole, although before the age of forty the rate is higher for women. The average length of life is shortened to the extent of about two years among women and twenty months among men because of heart disease deaths.[5]

There seems to be no clear evidence that occupation or trade, of and by itself, is a determining factor in the incidence or death rate of heart disease.

> Among 100,000 men and women applying for general industrial work in cities, about one and one-half per cent will be found to have some heart disease, but this is no higher an incidence than is found in the general population of the same age.[6]

Heart disease takes its toll in sickness and disability as well as in death. Diseases of the heart and blood vessels cause a greater volume of disability than any other single

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[4] George Dock, "Candidates for Heart Attack," Harper's Magazine, 193:130-134, August, 1946.

[5] Haven Emerson, "The Prevalence of Diseases of the Heart as Sickness and Cause of Death," Diseases of the Heart, American Heart Association, Inc., June, 1937, p. 10.

[6] Ibid, p. 10.

chronic disease.

> They are responsible for a loss of 152,100,000 days annually. More than 200,000 men and women are invalids as the result of heart diseases, arteriosclerosis and high blood pressure.[7]

Among children of the low income groups, heart disease has been found more prevalent than among children of the privileged. Paul and his associates have found that heart disease among school children of the poor sections of the city was one and one-half times the incidence in those attending public schools in better sections and eight times as high as in children of the well-to-do, attending neighboring private schools.[8]

The influence of geographic and climactic factors has been repeatedly stressed in literature on heart disease. Nichol, in a comparative study of the incidence of rheumatic heart disease in Florida and New England, found that hospital admissions for rheumatic fever in Boston were ten times as high as in Miami.[9]

Furthermore, he observed that the incidence of heart disease among children migrating from the North to Miami was four times as high as that of a similar series who were

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[7] American Heart Association, Inc. op. cit.

[8] J. R. Paul, and others, "The Social Incidence of Rheumatic Heart Disease, A Statistical Study in New Haven School Children," American Journal of the Medical Sciences, 188:301, 1934.

[9] E. S. Nichol, "Geographic Distribution of Rheumatic Fever and Rheumatic Heart Disease in the United States," Journal of Laboratory and Clinical Medicine, 21:588, 1936.

natives of the South.

The economic loss due to heart disease is staggering in terms of morbidity, physical disability, mental anxiety, loss of productivity and loss of self-reliance. Heart disease imposes a tremendous burden upon its victims, upon their immediate families and upon the community.

Types and Causes of Heart Disease

One of the greatest advances of all time in the study and treatment of heart disease, and probably the greatest in this generation, according to Dr. Paul D. White, has been the clear differentiation of heart disease into its various types and kinds.[10] Dr. White points out that this step has been of vital importance not only for the proper understanding and treatment of individual patients, but also, and even more, for directing medical attention to the causes of heart disease and thereby establishing a solid foundation on which to build up the campaign of prevention of these causes.[11]

> It is important to recognize that heart disease is not one disease but a multiple of diseases, of which the following are the principal kinds: congenital heart disease, rheumatic heart disease, subacute bacterial endocarditis, cardiovascular syphilis, hypertensive heart disease, and coronary heart disease. This list is arranged chronologically from birth to old age. Not infrequently, different kinds are combined, especially rheumatic heart disease and subacute bacterial

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[10] Paul D. White, "The Causes and Kinds of Heart Disease and Their Prevention," Diseases of the Heart, American Heart Association, Inc., June, 1937, p. 13.

[11] Ibid.

endocarditis or hypertensive heart disease and coronary heart disease.[12]

Rheumatic fever is perhaps the most important of all causes of heart disease. This disease is most common in the north temperate zone and its incidence is greatest among children of school age. By far, the largest number of its victims are among the children of the poor. Infections in general, and upper respiratory infections in particular, seem to predispose recurrences of rheumatic fever.[13]

In the very young, heart disease may also be due to congenital defects. They may be mild or severe, allowing a fairly long life or causing early death.

The heart may become temporarily or permanently affected by certain acute diseases of childhood such as diphtheria, severe lung infections and, on rare occasions, by scarlet fever.

In both the young and the adult, the heart is subject to direct or indirect injuries. "In the course of such accidents the heart may sustain a contusion or a laceration, but such cardiac injuries are actually rare."[14]

Syphilis has been a prominent cause of cardiovascular

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[12] __________," Heart Disease: Twenty-seven Questions Answered," _op. cit._

[13] Irving Roth, _Problems in the Prevention and Relief of the Heart_, American Heart Association, Inc.

[14] _Ibid._

disease in the past, is still a common cause in some communities, but is a relatively infrequent factor in places where preventive medicine, diagnosis and treatment are highly developed.[15]

Disease of the thyroid gland may seriously affect the heart, especially in the middle-aged, and hypertension, an abnormally high blood pressure, persisting over several years, also generally leaves its imprint upon the heart.

Unfortunately, very little is known about arteriosclerosis of the coronary arteries which is the most common cause of heart disease in adults. The cause of arteriosclerosis is still unknown and therefore, prevention of arteriosclerotic heart disease has but a limited application.[16]

Symptoms and Diagnosis

Dr. Paul White lists three characteristic symptoms of heart trouble, of which the most important is angina pectoris, which is often described as not a pain but an oppression under the breastbone on exertion, sometimes radiating to the arms and lasting only a minute or two, subsiding with rest and/or nitroglycerine.[17] This symptom of angina pectoris should not be confused with what might be

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[15] Paul D. White, "The Causes and Kinds of Heart Disease and Their Prevention," op. cit., p. 16.

[16] Irving Roth, op. cit.

[17] Paul D. White, "Heart Disease: Twenty-Seven Questions Answered," op. cit.

indicative of pains which come to people with various states of fatigue or mental distress.

Shortness of breath may be the result of heart disease and of the failure of the heart muscle, but is much more commonly due to other troubles such as abnormality of the lungs, infection of the upper respiratory tract, physical unfitness, obesity, and nervousness.

> When coronary symptoms are mild, the attacks are often mistaken for indigestion, attacks of asthma or bronchitis. Sometimes a sudden shortness of breath unrelated to exertion may take the place of pain in coronary occlusion.[18]

Palpitation, which is a sense of rapid, regular heart beat, rapid irregular action, or slow pounding interrupted "skipping" of the heart, is commonly experienced by nervous people with normal hearts or after special effort, as well as in individuals with heart disease itself. It has to be analysed carefully. Generally it is relatively unimportant.

> The most important method of diagnosis is that of careful and accurate history-taking. That makes up about fifty per cent of the value of the total examination. The physical examination itself, with the use of the stethoscope and blood pressure machine, makes up another thirty per cent. The electrocardiogram, a graphic record of the electrical action of the heart, which is often important and may reveal a clue to the diagnosis, rates, however, far less than the other methods of examination already mentioned. It deserves a rating of about ten per cent. X-ray examination, which is often much exaggerated by the lay public, has a value of about five per cent; it is often helpful for

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[18] Peter J. Steincrohn, "When the Heart Suffocates", Science Digest, October, 1946.

confirmation and affords a clue occasionally. All other methods of examination make up the remaining five per cent. As time goes on, with the development of new tests, there may be a change in this percentage of values.[19]

Treatment

The first step in the treatment of heart disease is to have a concept of the situation to be met. Dr. C. Sidney Burwell states that the treatment of heart disease has two objectives; "the control or cure of the underlying processes; and the prevention, postponement or relief of those abnormalities in function."[20]

Dr. Burwell outlines the main factors in the treatment of congestive heart failure:

1. The conservative management of the primary causes of heart disease and of the precipitating factors.

2. Reduction of the work of the heart by
    a. The limitation of bodily activity
    b. The induction of sleep
    c. The reduction of heart rate
    d. The reduction of body weight

3. The effective use of digitalis.

4. Proper utilization of the assistance of diuretics in controlling the fluid balance of the body.

5. The administration of a diet adjusted to the patient's needs as well as to his limitations.

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[19] Paul D. White, "Heart Disease: Twenty-Seven Questions Answered," op. cit.

[20] C. Sidney Burwell, "The Treatment of Heart Disease," Diseases of the Heart, American Heart Association, Inc., p. 33.

6. Certain special procedures to meet special emergencies.
    a. Venesection (in sudden failure with marked distension of veins or in alarming pulmonary edema).
    b. The removal of fluid from serous cavities.
    c. The use of oxygen in treating pulmonary edema which does not respond favorably to morphine.

7. The adjustment of the patient's life and philosophy to his disability.[21]

To relieve a patient suffering from heart disease is to meet all his needs adequately. It must be realized that the care of a patient with heart disease is a continuous responsibility from the beginning of his illness to the end of his day. This is a medical axiom.[22]

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[21] Ibid.

[22] Irving R. Roth, op. cit.

CHAPTER IV

MEDICAL ASPECTS OF PATIENTS' ILLNESSES

Of the forty-five patients studied, sixteen were found to have no cardiac diagnoses following their initial examination in the clinic. Five of these patients were referred from the Medical Clinic, three from the Evans Department, two from the Prenatal Clinic, one from the Gastro-Intestinal Clinic, one from the New England Hospital for Women and Children, and two patients were referred by private physicians. These fourteen patients were referred for evaluation of their cardiac status. Two patients were self-referred because of their symptoms of heart disease.

Ten of these sixteen patients were given no medical recommendations. Two of these ten were asked to return in one year to the clinic for a routine physical examination.

One woman was advised to have an operation for adenoma of the left lung. This operation was performed at the hospital.

One woman was referred back to the Endocrine Clinic from whence she had been referred because of symptoms which were believed to have a cardiac origin.

Another woman was advised to take sodium amytal and was

given reassurance. In this particular case, a diagnosis of psychoneurosis was made, but the patient was not referred to the Psychosomaic Clinic.

One man was advised to control his diet and "take it easy." He was not asked to return.

Two patients were referred to the Medical Clinic. One for weight reduction, and the other for a routine examination. Both of these patients were followed in the Medical Clinic.

The twenty-nine patients with cardiac diagnoses evidenced many types of heart disease. In several instances, a patient had a combination of diseases which accounts for the duplication in the total number of patients in the following table. Table 1, page 26, points out the wide range of types of heart disease seen in the clinic during the three month period.

Table 1

MEDICAL DIAGNOSES OF TWENTY-NINE PATIENTS WITH HEART DISEASE

Diagnosis	Number of Patients
Angina Pectoris	2
Aortic Insufficiency	2
Arteriosclerotic Heart Disease	4
*Class IIB	2
*Class IIC	1
Congenital Heart Disease	3
Essential Hypertension	4
Mild Congestive Heart Disease	1
Mitral Stenosis and Insufficiency	3
Myocardial Infection	1
Possible Heart Disease	1
Rheumatic Heart Disease	7
Syphilitic Heart Disease	2
Total Diagnoses	33

*Infra, p. 27.

As can be seen, only three patients were typed according to the classification distributed by the American Heart Association. Ideally each patient should have fallen into one of the following groups:

Functional Capacity

Class I	Patients with cardiac disease and no limitation of physical activity. Ordinary physical activity does not cause discomfort.
Class II	Patients with cardiac disease and slight limitation of physical activity. They are comfortable at rest but on ordinary physical exertion experience discomfort in the form of undue fatigue, palpitation, dyspnea or angina pain.
Class III	Patients with cardiac disease and marked limitation of physical activity. They are comfortable at rest but the above symptoms are caused by less than ordinary activity.
Class IV	Patients with cardiac disease who are unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, are present, even at rest.

Therapeutic Classification

Class A	Patients with cardiac disease whose physical activity need not be restricted.
Class B	Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against unusually severe or competitive efforts.
Class C	Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous habitual efforts should be discontinued.

Class D	Patients with cardiac disease whose ordinary physical activity should be markedly restricted.
Class E	Patients with cardiac disease who should be at complete rest, confined to bed or chair.
Potential Heart Disease	Patients in whom no cardiac disease is discovered, but whose course should be followed by periodic examinations because of the presence or history of an etiological factor which might cause heart disease.
Possible Heart Disease	Patients with symptoms or signs referable to the heart but in whom a diagnosis of cardiac disease is uncertain.[1]

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[1] Criteria Committee of the New York Heart Association, The Classification of Patients with Diseases of the Heart. Adopted and distributed by the American Heart Association.

The medical recommendations were as varied as the diagnoses. Only fourteen of the twenty-nine patients were given medical recommendations. Here again, several patients were advised to take more than one type of medicine which accounts for the duplications evidenced in Table 2, page 30.

Of the fourteen patients who were taking pharmaceutical preparations, only one person was not able to obtain the prescribed medication due to lack of finances. However, several of the others stated that the high cost of the various medicines necessitated very close budgeting of the family income. These patients related that since medication was vital to their health, they sacrificed other needs to obtain the medicine. Medical care cuts deeply into the family income, with the result that these patients have to economize on general living expenses, durable goods and housing for which normally their money would be used.

Table 2

MEDICAL RECOMMENDATIONS GIVEN TO
FOURTEEN PATIENTS WITH CARDIAC DIAGNOSES

Recommendation	Number of Patients
Annion Chloride	1
Bed rest	1
Belladona	2
Diet	7
Digitalis	4
Digitoxin	2
Hospitalize for observation	1
Mercuzan	1
Nitroglycerine	1
Phenobarbital	4
*Reassurance	2
Sodium Barbital	1
Vitamin B Complex	1

*In discussing the term "reasurrance" with one of the physicians, the writer was informed that reassurance is considered to be a medical recommendation. The doctor himself reassures the patient.

Table 3, page 31, points out the type of diet given to eighteen patients.

Table 3
DIETS FOR EIGHTEEN PATIENTS

Diet Ordered	Number of Patients
Salt Free	3
Low Calorie	4
No Special Diet	11
Total number of patients	18

All seven patients for whom diets were ordered, stated that they were able to follow these diets.

While the patient is treated for his symptoms and complaints, measures are employed to prevent recurrent attacks of the disease causing the cardiac disorder. Treatmentis directed also with a view to adapting the patient to carry on within the limited sphere of endeavor determined by his handicap. Depending upon circumstances which alter the functional capacity of the cardiac patient from time to time, periodic readaptations may be necessary.[2]

In respect to follow-up at the clinic for the

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[2] Irving Roth, op. cit.

eighteen cardiac patients, twelve are regularly attending the clinic at varied intervals according to the individual's need, four were discharged, six were told to return if necessary, and seven patients who were asked to return to the clinic, did not keep their appointments.

The aforementioned treatment recommendations were the only ones that the writer was able to tabulate from the information obtained from the medical records.

CHAPTER V

GENERAL CHARACTERISTICS OF PATIENTS' SOCIAL PROBLEMS

In order to give a more complete picture of the patients studied, some statistical data are included regarding the general characteristics of these people as revealed by the schedule[1] and questionnaire[2] that were used.

Table 4, page 34, gives the ages of the twenty-nine patients who were diagnosed as having heart disease. Although the Adult Cardiac Clinic actually serves patients over twelve years of age, it will be seen that three patients under twelve were admitted. The writer was informed that the clinic makes an exception in the regulation concerning age in the cases of patients who are suffering from congenital heart disease.

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1 For copy of schedule, see pp. 64, 65.
2. For copy of questionnaire, see pp. 66, 67.

Table 4

AGES OF TWENTY-NINE PATIENTS WITH CARDIAC DIAGNOSES

Ages in Years	Number of Patients
0----4.9	2
5----9.9	1
10--14.9	0
15--19.9	1
20--24.9	0
25--29.9	2
30--34.9	1
35--39.9	1
40--44.9	5
45--49.9	3
50--54.9	3
55--59.9	3
60--64.9	2
65--69.9	2
70--74.9	2
75--79.9	1
Total number of patients	29
Average age	46.1 years

It will be seen from the foregoing table that the greatest number in any one group fall within the forty to 44.99 year group. There were eight patients younger than this group as compared to sixteen older. The average age for the entire group is 46.1. Despite the fact that this average is derived from a relatively small number of patients, it is interesting to compare it with a fact which has previously been mentioned, namely, that one out of every five persons in the United States over the age of forty-five has some form of heart disease.

Table 5, page 35, shows sex of the twenty-nine patients with cardiac diagnoses.

Table 5

SEX OF TWENTY-NINE PATIENTS
WITH CARDIAC DIAGNOSES

Sex	Number of Patients
Male	14
Female	15
Total number of patients	29

In this group of patients, the sex was almost equally divided. Fifteen, or 51.7 per cent, were male, whereas fourteen, or 48.3 per cent were female. The average age for the men was 48.8 in contrast to the average age for

the women which was 44.1.

One might wonder if heart disease affects marriage to any appreciable degree. Table 6, page 36, gives a picture of the marital status of the twenty-nine patients with cardiac diagnoses.

Table 6

MARITAL STATUS OF TWENTY-NINE PATIENTS
WITH CARDIAC DIAGNOSES

Marital Status	Number of Patients
Single	5
Married	17
Widowed	3
Separated	3
Divorced	1
Total number of patients	29

Of the five single patients, three were under ten years of age, one patient was thirty-seven, and the other, fifty-five. It must be remembered that of course not all patients with heart disease are crippled in any degree, and that these should be encouraged to lead normal lives with the exception of strenuous exercise. Furthermore, many others even with advanced heart disease can carry on for many years under proper guidance and adequate medical

care.

A natural question to ask is where these patients live. The Massachusetts Memorial Hospitals serve patients from all over the state of Massachusetts, as well as individuals from neighboring states. However, it is reasonable to expect that most of the patients who are treated in the Cardiac Clinic will be located in places from which the hospital will be easily accessible.

The writer was able to ascertain the residence of the forty-five patients who were seen for the first time in the clinic from the identifying data provided in the medical records. All forty-five residences were tabulated in order to give a clearer picture of the locations of individuals who visit the clinic. This is pointed out in Table 7, page 38. Most of these locations are near enough to the hospital so that the patients may easily attend the clinic as regularly as recommended by the physician. In the cases of the two patients from the furthest points, Cohasset and Hudson, each was not required to come back to the clinic for one year.

Table 7

RESIDENCE OF THE FORTY-FIVE PATIENTS AT TIME OF REGISTRATION

City or Town	Number of Patients
Boston	15
Cambridge	1
Cohasset	1
Dedham	1
Dorchester	3
Everett	2
Hudson	1
Malden	2
Mattapan	2
Quincy	2
Roslindale	2
Roxbury	8
Waltham	1
Weymouth	1
Total number of patients	45

Table 7

RESIDENCE OF THE FORTY-FIVE PATIENTS AT TIME OF REGISTRATION

City or Town	Number of Patients
Boston	15
Cambridge	1
Cohasset	1
Dedham	1
Dorchester	5
Everett	2
Hudson	1
Malden	2
Mattapan	2
Quincy	2
Roslindale	3
Roxbury	8
Waltham	1
Weymouth	1
Total number of patients	45

It was only possible to determine the ability of the eighteen patients who were interviewed to return to the clinic. The medical records supplied this information that is recorded in Table 8, page 39.

Table 8

ABILITY OF EIGHTEEN PATIENTS
TO RETURN TO CLINIC

Residence	Can Return to Clinic	Can not Return to Clinic
Boston	5	1
Greater Boston*	6	1
Outside of Boston	5	—
Totals	16	2

*Includes Dorchester, Mattapan, Roslindale and Roxbury.

Of the group of eighteen patients on whom full reports were obtained, only two stated that they were unable to return to the clinic. In both instances, the reason was poor health which necessitated bed rest. No provisions were made if the patient felt unable to return to the clinic.

The amount and kind of exercise indulged in by cardiac patients is, of course, a highly individual problem which has to be worked out in each case by the physician in light of his knowledge of the patient's condition. However,

the working rule for the limitation of activity in patients with heart disease is to permit exercise which does not produce abnormal shortness of breath or undue fatigue. For that reason, the place of abode is of importance. It is evident that excessive stair-climbing may produce shortness of breath or fatigue. Table 9, page 40, shows the place of abode of the eighteen patients who were interviewed.

Table 9

PLACE OF ABODE OF EIGHTEEN PATIENTS

Floor	Use of Whole Apartment	Room in a Rooming House
First	4	
Second	6	
Third	4	2
Cottage	2	

Ideally, all of these patients should live on the first floor. Unfortunately, six of the eighteen, or one-third of the group reside on the third floor. In view of the housing situation today, probably very little could be done to alleviate this problem. There were no attempts made to clarify this problem.

Table 10

LIVING CONDITIONS OF EIGHTEEN PATIENTS

Persons with whom Living	Number of Patients
Husband or wife	12
Parents	3
Children	2
Alone	1
Total number of patients	18

As is shown in Table 10, page 41, the majority of the patients lived with their consorts. Only one patient lived alone. Therefore, these patients were able to share their problems with members of their family whome we presuppose would be sincerely interested in the welfare of the patient.

Table 11, page 42, depicts the monthly rent paid by twelve patients.

Table 11

MONTHLY RENT PAID BY TWELVE PATIENTS

Rent	Number of Patients
$16.	1
20.	3
25.	1
26.	1
30.	1
33.	1
37.	1
40.	3

Of the eighteen patients, six owned their own homes. The average monthly rent of the twelve remaining was $29. This low rental is indicative of the fact that the majority of these patients live in low rental areas where housing conditions are often far from adequate. It has been found that most victims of rheumatic fever, which accounts for more than one-third of the crippled hearts in adult life,[3] are found among the needy population of our larger cities where overcrowding, undernutrition and unfavorable hygienic surroundings prevail. Inadequate housing may be a highly

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[3] Edward Bland, Rheumatic Heart Disease in Children, American Heart Association, Inc.

important factor. There is evidence that rheumatic fever occurs most frequently not just in poor neighborhoods, but in houses that have been made damp and drafty by poor cellars, leaky roofs or broken windows.

Table 12, page 44, points out the ages, source of support, monthly income, and number in family of eighteen patients.

The majority of these patients are supported by wages. Two depend on rent from property, two are aided by the Department of Public Welfare, and four patients are supported by their families. Eighty-seven and five-tenths per cent of those patients fifty-five years old and younger are dependent on wages, as contrasted to twelve and five-tenths per cent of those patients who are older than fifty-five. The average number in the families of these patients was two and eight-tenths per cent persons.

In order to determine a standard budget, the writer used the guide for establishing a minimum family budget which is published by the Visiting Nurse Association of Boston.[4] For a family of three adults, the income necessitated to achieve an acceptable standard of living is $150. a month. Two families, or slightly over ten per cent of the eighteen patients, are receiving aid from the

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[4] Visiting Nurse Association of Boston, The Minimum Family Budget, Nutrition Service, Visiting Nurse Association, Boston, Massachusetts, July, 1948.

Table 12

AGES, SOURCE OF SUPPORT, MONTHLY INCOME AND NUMBER IN FAMILY OF EIGHTEEN PATIENTS

Ages	Rent from Property	Wages	Family	Public Welfare	Pension	Number in Family
3			$180.			5
19		$200.				3
27		$200.				3
29		$124.				3
37			I.A.[1]			3
45				N.R.		2
45		$190.				6
50		$180.				3
51		$200.				4
55		N.R.				1
56					$58.	2
58			$140.			3
59		$80.				2
70				$81.		2
71	$52.					2
71					$53.	2
75			I.A.			2
76	$56.					2
Totals of Sources	2	8	4	2	2	

[1] Indefinite amount

Table 12

AGES, SOURCE OF SUPPORT, MONTHLY INCOME AND NUMBER IN FAMILY OF EIGHTEEN PATIENTS

Ages	Rent from Property	Wages	Family	Public Welfare	Pension	Number in Family
3			$180.			5
19		$200.				3
27		$200.				3
29		$124.				5
37			I.A.[1]			3
45				N.R.		2
45		$190.				6
50		$180.				3
51		$200.				4
55		N.R.				1
56					$58.	2
58			$140.			3
59		$80.				2
70				$81.		2
71	$52.					2
71					$53.	2
75			I.A.			2
76	$56.					2
Totals of Sources	2	8	4	2	2	

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[1] Indefinite amount

Department of Public Welfare. Only three families, or seventeen per cent, receive incomes over the minimum budget. Therefore, it may be seen that almost seventy-three per cent of the patients interviewed are receiving incomes below the standard budget.

It was not possible to determine the monthly income of all of the eighteen patients. One patient would not reveal the amount of his salary. One stated that he had no income at all and intended to apply for aid from the Department of Public Welfare the following day. Another received an indefinite amount from her children, and a fourth was cared for financially by his parents. The average monthly income for fourteen patients was $128. which is definitely in the low income group. As has already been stated, heart disease is much more prevalent among children of the low income groups than among children of the privileged. With this in mind as a vicious circle, the cardiac problem looms high indeed.

The problem is met by a timely diagnosis and prompt treatment, but of equal importance is the task of the community in raising the standard of living by providing adequate food, shelter and clothing. To raise the level of living conditions is to complement the efforts of the medical profession in its endeavor to improve general health.

Such collaboration is essential.

The occupations and activity required of eighteen patients is pointed out in Table 13, page 47.

Activity was determined by the degree of physical exertion demanded of the individual by his occupation. All sedentary occupations were classified as "limited activity." All occupations which necessitated a patient to be constantly on his feet with little opportunity for rest were classified as "unlimited activity." In the cases of the housewives, activity was determined by the work which these women did to care for their homes. The women who had help and were required only to do some light housekeeping were classified as "limited activity." Those women on whose hands rested the care of the entire household, including laundry and washing floors, were classified as "unlimited activity."

The majority of those suffering from heart disease are able to work and earn their own living. Many of them are able to perform even the hardest labor without doing themselves harm. An increase in the severity of the damage is much more likely to come from a continuation of the course of the original disease than from the overstrain of a slightly damaged heart.

Table 13

OCCUPATIONS AND ACTIVITY REQUIRED OF EIGHTEEN PATIENTS

Occupations	Limited Activity	Unlimited Activity	No Activity
Male			
Full-time			
Porter		1	
Price Sorter	1		
Retired			3
Time-Study	1		
Young Child			1
Welfare Recipient			1
Part-time			
Restaurant worker		1	
Shoe worker		1	
Female			
Full-time			
Dress Trimmer		1	
Housewife			1
Housewife	3		
Housewife		3	
Total number of patients	5	7	6

Each patient should find an occupation which demands less than he is well able to perform, for only in this way will he avoid the probability of frequently overtaxing his endurance. In this matter, the judgment of a physician is always advisable.

CHAPTER VI

SOCIAL SERVICE ACTIVITY

The Social Service Department of the Massachusetts Memorial Hospitals divides its cases into three main groups; namely, comprehensive cases, limited services and unrecorded services. The first two divisions meet the requirements set up by the Statistics Committee of the Medical Social Section of the Greater Boston Community Council.

A Comprehensive Case is determined by the following criteria:

1. Recognition of the relation of personal and/or social situation to the problem of medical care.
2. Review or study which takes into account the multiple aspects of such a problem rather than being directed toward a single limited aspect of care.
3. Carrying through of planned service in terms of social treatment, or making a decision not to carry through such service, based on medical social study.
4. Permanent recording which is indexed for reference within the agency.

A Limited Service is one which is given to a particular patient or patient group for the purpose of helping solve a problem related to the patient's medical situation. It should be kept in mind that although it is a case work service requiring individualization and case work skills, the attempt is to meet only the immediate, or presenting problem and the service is limited in scope. It differs from Comprehensive Service, therefore,

in degree and goals.[1]

One of the types of limited service which is particularly pertinent in the Cardiac Clinic is the social review, for the American Heart Association specifically lists as one of the duties of the social worker in this clinic that "the social worker should be present during the entire clinic session and should have an interview with all patients on their initial visit to the clinic."[2]

The social review is for the purpose of:

1. determining the social situation in relation to medical needs.
2. clarifying need of service
3. increasing security
4. providing a basis for medical follow-up[3]

An unrecorded service is one which is not recorded in permanent form and, in general, embraces all minor services for which patients and outside agencies turn to a social service department. For example, a patient was wandering about the hospital in a seemingly confused state. He asked one of the social workers where a certain clinic was located, for he had been told to report there the following

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[1] Greater Boston Community Council, Statistics Committee, Medical Social Session, Standards for Statistical Accounting of Medical Social Service, June, 1946.

[2] American Heart Association, Inc., Standard Requirements for a Cardiac Clinic.

[3] Greater Boston Community Council, op. cit.

week. He carried with him a prescription which he did not know where to have filled. The social worker took him to the hospital pharmacy and then pointed out the clinic where he was to report. Since this gentleman was quite old and did not seem to be in condition to travel home alone, the worker made arrangements for transportation by taxi.

In order to obtain some sort of a quantitative count of unrecorded services, each such service is listed on the monthly statistical sheet.

Table 14, page 51, shows the extent of social service activity on the forty-five patients and the types of services offered.

Table 14

SOCIAL SERVICE ACTIVITY ON FORTY-FIVE PATIENTS FOR THE MONTHS OF JANUARY, FEBRUARY, MARCH, 1947

Types of Service	Parients With Cardiac Diagnoses	Patients Without Cardiac Diagnoses
Comprehensive	0	0
Limited (Social Review)	8	4
Unrecorded	0	0
None	21	12
Total number of patients	29	16

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As can be seen, there was very little social service activity during those three months. In fairness to the social service department, it must be explained that during this time there was a turnover in the department and there were two different social workers in the Cardiac Clinic in this short interval. The Cardiac Clinic has to fit in with the Out-Patient Department of the hospital. Through observation, the writer feels that at the present time the Out-Patient Department is not too well coordinated due to the rapid growth of this department which has produced certain problems such as lack of space and a dearth of personnel in some instances. It is the writer's impression that with the coming of a new administrator some of the current situations may be considered for reorganization.

It is the function of the medical social worker to help the patient utilize the prescribed medical treatment to the greatest advantage. The problems involved in the treatment of cardiovascular disease are common to both urban and rural communities. The first problem is the person who is unable to pay the physician's fee and laboratory costs at private fees, and it is this type of patient who applies for medical treatment in the heart clinics of the various hospitals of the larger cities. Most of these clinics are equipped to render the needed service at a charge within the means of the patient, or

entirely without cost to him, if necessary. The clinic physician and his assistants examine the patient, make the diagnosis and prescribe the treatment. However, successful medical treatment depends in some cases on the social factors involved. Consequently, trained social workers are a necessary addition to the staff in all large hospitals.

In a busy heart clinic, it is impossible for the physician to be familiar with the personality and social status of each patient. The physician outlines the regime of treatment, but often other obstacles prevent proper execution of these plans. Success in treatment may depend on bed rest at home, convalescent care, a quiet environment, freedom from anxiety, better nourishment, warmth, employment which will not tax the heart and a host of other adjustments. A patient may require the services of a competent social worker so that adequate social and economic adjustments may be made.

During childhood, special school supervision and vocational guidance may be necessary. In young adulthood, problems pertaining to courtship, marriage, pregnancy, childbirth, and the added burden of rearing an infant must be intelligently met. The medical social workers concentrate most of their attention on these matters.

The first task of the worker is to individualize the patient for the physician. Then she supplements the

physician's instructions by a detailed interpretation of every item of his diagnosis and treatment. It is vitally important for the patient to understand fully his physical condition so that his problem may not be complicated by unnecessary fear of chronic invalidism or sudden death.

The social worker can also assist the patient in adjusting personality problems. Frequently, the patient has to be helped to express his fears, resentments, and bewilderments, before treatment can be carried on successfully. The patient can also be aided in utilizing his community resources with regard to his occupational and recreational life, and the development of all of his capacities as much as possible within his limitations.

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The social worker can also assist the patient in adjusting personality problems. Frequently, the patient has to be helped to express his fears, resentments, and bewilderments, before treatment can be carried on successfully. The patient can also be aided in utilizing his community resources with regard to his occupational and recreational life, and the development of all of his capacities as much as possible within his limitations.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The original purpose of this study was to learn how many patients were receiving assistance from the Department of Public Welfare and to learn if the patients under treatment in the Cardiac Clinic had adequate facilities to carry out the physician's recommendations such as opportunity for rest, proper diet, medication and transportation to clinic.

The forty-five patients who were seen in the clinic for the first time during the months of January, February and March, 1947, were studied. The medical records on these patients were first consulted for identifying data, diagnosis and recommendations for medical care. Sixteen of these patients were not discovered to have any type of heart disease and were either discharged or referred to other clinics in the hospital. Twenty-nine patients had diagnoses of heart disease. Questionnaires, completed by the Visiting Nurse Association, together with home visits by the writer were employed to gather the desired information. It was discovered that of the original twenty-nine patients with cardiac diagnoses, three had died, one was hospitalized, and seven could not be located. The latter

group were not living at the addresses which had been recorded at the time of registration, and all attempts to locate them were fruitless. Complete schedules were filled out on eighteen patients.

It was discovered that the majority of the patients who were interviewed were supported by wages. Only two, or slightly over ten per cent of these individuals, were dependent on assistance from the Department of Public Welfare.

Only three families, or seventeen per cent, receive incomes over the minimum budget as set by the Visiting Nurse Association of Boston, Therefore, it may be seen that almost seventy-three per cent of the patients who were interviewed are receiving incomes below the standard budget. Although this latter group does not receive aid from the Department of Public Welfare, it is evident that financial problems exist here.

The average monthly income for the group was $128, which today for an average family is not an adequate income level. Many patients stated that the cost of medication was a definite strain on the family finances.

As was pointed out in Chapter I, it was impossible to learn if these patients were following the physician's recommendations as he had intended. However, certain generalizations can be made concerning the medical-social aspects of the group.

The average age of those patients studied was forty-six years and one month. The sex was almost equally divided. Fifteen patients were male and fourteen were female. In respect to marital status, seventeen were married; five, single; three, widowed; three, separated; and one was divorced. It was evident that the presence of heart disease in these patients did not interfere with marriage and the pursuit of a normal life with individual limitations.

The majority of the patients resided in localities which are reasonably near the hospital. Six patients lived in Boston, seven, in Greater Boston and five lived in communities outside of Boston. There appeared to be no problem of transportation. The two patients who could not return to the clinic for periodic examinations were both ill and confined to the home.

In respect to living conditions, it was found that this group of patients, on the whole, lived in low rental districts. The average monthly rent was $29. Inadequate housing is a very important factor in heart disease, particularly in regard to rheumatic heart disease. Poor housing facilities is one of the conditions that appears to favor the presence of rheumatic fever.

Only one patient lived alone. We would like to feel that the others could look to members of their family for aid both physically and emotionally.

The occupations of the eighteen patients were varied. Limited activity was required of five patients, unlimited activity, of seven patients, while six patients experienced no activity. The type of occupation best suited to the cardiac patient is a highly individual problem. The selection of an occupation must depend primarily upon the mental equipment, education and previous training of the individual. Here ingenuity and thought on the part of the physician and social worker may be advantageously exercised. There are but few cardiac patients who cannot do something to earn a living and many of them can earn as high wages as if they had no disease whatsoever.

All of those patients who were given special diets stated that they were able to comply with the limitations set forth.

Seven of the eighteen patients, or thirty-nine per cent, did not keep their appointments to return to the clinic. The success certain heart clinics have in the treatment of their patients is dependent to a great degree upon the faithfulness with which these patients keep their appointments for return visits. This faithfulness again depends upon what the patient thinks of his doctor and what interest the doctor displays in his patient. It is here too that the social service department associated with the clinic plays one of its most important roles. The

social worker is the contact, the living representative of the often cold clinic, and her efforts in the home may mean more patient visits to the clinic. Persistence and tact is rewarded by a large percentage of honored appointments.

Social service activity during the three month period was inadequate. At the present time, however, a social worker is present during the entire clinic session and interviews all patients on their initial visit to the clinic.

Some of the most distressing problems both for the cardiac patient and his family arise from prolonged financial or physical dependence on relatives or the community, inability to develop individual capacities or to realize ambitions for self or family, interruption in the continuity of normal pursuits, and of usual human relationship, and the constant dread of impending physical disaster.

After the physician and the patient together have established the limits of the patient's physical activity, the patient should have a thoughtful interpretation of his condition which will place positive emphasis on his possibilities for attaining some of the satisfactions of life. The social worker and the physician should collaborate with the patient in analyzing the patient's needs so that the social worker may have the opportunity for significant,

constructive service to the patient and his family.

A program of care is incomplete that does not give equal attention to the preventive aspects and the therapy. Prerequisites of such a program are regular medical attention for an indefinite period; avoidance of infection, emotional stress, and undue physical activity; adequate nutrition; and a plan of work and recreation suited to the individual's limitations and interests. Schooling and occupational therapy for children in institutions and in their homes and sheltered workshops and recreational facilities for adults should be fostered by the community. Medical, social and psychiatric services are required in many cases. These objectives are attainable when there exists a relationship of mutual understanding among physicians, patients, families, social workers and all others who are trying to diminish the disability in persons ill with heart disease.

The writer would like to make two recommendations. First, that all patients with heart disease be classified in accordance with the criteria as outlined by the American Heart Association, and that the doctors indicate clearly their recommendations, and secondly, that some consideration be given to the possibility of a program of cooperation with the Visiting Nurse Association in regard to care of the cardiac patient in his own home. Not only could

these nurses provide for routine nursing care, but also could furnish resources for occupational therapy if needed.

The writer also believes that it would prove helpful to have a future study in which the doctors' recommendations were made carefully, and a student followed them up in a study.

Approved,

Richard K. Conant

Richard K. Conant
Dean

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Schedule

Identifying Information

1. O.P.D.# 2. S.S.R.#

3. Name

4. Address

5. Birthdate 6. Birthplace 7. Sex

8. Race 9. Religion 10. Citizenship

11. Marital Status
    a. Single -- Married -- Widowed -- Separated -- Divorced
    b. Name of parents, consort or relative
    c. Occupation of same
    d. Income of same
    e. Number of children
    f. Ages of children
    g. Are children working?

12. Occupation
    a. Type of activity necessary

13. Living conditions
    a. With consort
    b. With parents
    c. With relatives
    d. With friends
    e. Alone

14. Place of Abode
    a. Room in rooming house
    b. Room in private family
    c. Use of whole tenement or house
    d. Own home
    e. Floor
    f. Location of bathroom
    g. Opportunity to eat in?

15. Income

16. Source of support
    - a. Wages
    - b. Aid from D.P.W. (Type)
    - c. Pensions
    - d. Savings
    - e. Miscellaneous

17. Rent

18. Source of referral

19. Reason for referral

Medical Aspects

20. Length of time under treatment at hospital
    - a. First seen
    - b. Last seen
    - c. Regularity in keeping appointments

21. Medical diagnosis
    - a. With complications

22. Other clinics attended

23. Present medical recommendations
    - a. Treatment
    - b. Medications
    - c. Cost of medications
    - d. Diet
        - 1. Was it ordered?
        - 2. Is it being followed?

24. Are there social problems connected with this illness?
    - a. Transportation to clinic
    - b. Housing
    - c. Insufficient income
    - d. Others

25. Discharge plans for patient
    - a. Social agency (signify)
    - b. Parents　　c. Relatives
    - d. Own home　　e. Hospitalization
    - f. Other

26. List agencies contacted and for what purpose

27. Social Work attempted?
    - a. Yes　　b. No　　c. Evaluation

Questionnaire

I. Name

II. Address

III. Marital Status
  - A. Single--Married--Widowed--Separated--Divorced
  - B. Name of consort, parent, or nearest relative
    - 1. Occupation of same
    - 2. Income of same
  - C. Number of children in the family
    - 1. Patient's children
    - 2. Siblings
    - 3. Ages
    - 4. Does income of employed children go into family group?

IV. Occupation of patient
  - A. Type of job
  - B. Degree of activity necessary

V. Conditions under which patient is living
  - A. Alone
  - B. With whom?

VI. Place of abode
  - A. Room in rooming house
  - B. Room in private family
  - C. Use of whole tenement or house
  - D. Own home
  - E. Floor
  - F. Location of bathroom
  - G. Opportunity to eat in?

VII. Income

VIII. Source of support
  - A. Wages
  - B. Aid from Department of Public Welfare (Type)
  - C. Pension
  - D. Savings
  - E. Miscellaneous

IX. Rent

X. Present Medical Recommendations
    A. Can patient obtain medications?
    B. If ordered, is a diet being followed?
    C. Can treatment recommended be carried out? (If not, why?)
        1. Expense
        2. Lack of supervision
        3. Other

XI. Are there social problems connected with this illness?
    A. Transportation to clinic
    B. Housing
    C. Insufficient income
    D. Others

XII. Additional comments on patient's medical or social situation:

Letter to Visiting Nurse Association

Visiting Nurse Association
Address
City, State

Dear Madam,

The physician in charge of the Cardiac Clinic of the Massachusetts Memorial Hospitals is very anxious that a study be made to discover if patients who are receiving public aid or who are in the small income brackets, are able to carry out medical recommendations such as opportunity for rest, diet, medication and transportation to clinic.

In working out this project, I have selected forty-five patients who have been under treatment at the clinic. We have discovered that a small percentage of patients being followed live in various outlying districts. Since it would be impossible for us to contact all the patients who we would like to reach, we wonder if your organization would be willing to cooperate with us in this study. It is quite likely that the one patient in your district in whom we are interested is already known to you, and you may have on file the information that we need.

We do not know what findings will come from this study, but the results may point out the advisability of a program of cooperation with the Visiting Nurse Association in regard to the treatment of cardiac patients in this section of the state.

Hoping that you are interested in participating in this study, I am taking the liberty of enclosing the name of the patient in your locality, and the questionnaire that we would like answered. If possible, we would appreciate receiving the questionnaire back by the end of January, 1948.

Very sincerely yours,

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